

**APPLICATION FOR VIRGINIA DEPARTMENT OF HEALTH STATE FUNDED ABORTION
UNDER SECTION 32.1-92.1 of CODE OF VIRGINIA (1982), AS AMENDED
FAX APPLICATION TO: (804) 864-7771**

Section 1: Patient Applicant Information
To be completed by Certifying Physician or Abortion Facility

Date of Application: _____ Name of Patient Applicant: _____
Date of Birth: _____ Address: _____
Medicaid Number: _____
Date of Procedure: _____ City/County of Residence: _____
Name and type of Facility: _____ ☐ Abortion ☐ Hospital
Name of Certifying Physician: _____

Section 2: Medical Information and Certification
Certifying Physicians must complete sections 2A and 2B.
Certifying Physicians must print name, sign and date

2A: I certify that my examination of the patient applicant and/or her medical record indicates that she is _____ weeks pregnant as of _____ (date)

Section 32.1-92.1: Cases of Rape or Incest

2B: I hereby request state funds under the provisions of § 32.1-92.1 of the **Code of Virginia** (1950) as amended. This pregnancy is the direct result of either rape or incest. The patient has verified that this event has been reported to a law enforcement or public health agency.

Date of Occurrence: _____ Date Reported: _____
Reported to: _____

Print name: _____

Certifying physician: _____ Date: _____

Section 3: Verification

Certifying physician license #: _____ License expiration date: _____

Facility license #: _____ Approved to provide abortions: _____ YES _____ NO

Section 4: VDH Physician Review

☐ Approved ☐ Not Approved

Rationale: _____

OFHS Deputy Director, or designee, Primary Physician Reviewer: _____ Date: _____

☐ Approved ☐ Not Approved

Rationale: _____

Secondary Physician Reviewer: _____ Date: _____

Section 5: Acknowledgement

Acknowledgement: "The Virginia Department of Health guarantees payment to the facility named in the application for performing an abortion on the individual named herein as the 'Patient Applicant'. Such payment shall be limited to the usual reimbursement rate established by the Virginia Medical Assistance Program (Medicaid), and shall constitute "full and final payment for such services." VDH reserves the right to deny payment if there is violation of the Code of Virginia.

OFHS Administration: _____

1. **Fax this application to: (804) 864-7771**
2. **Submit bills on CMS 1500 to:**
Reproductive Health Unit
Virginia Department of Health
109 Governor St.
9th Floor
Richmond, VA 23219
3. **Provide approved copy of this application to the patient applicant**
4. **Provide the abortion facility a signed copy for billing purposes**